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ABSTRACT

This booklet explores an issue that has only recently begun to receive widespread public attention: the mistreatment or neglect of elderly people within the home. What is known about mistreatment of the elderly by their families or by persons within their households is discussed in this document. It also explores what can be done about it, both in terms of intervention and the long-range solution: prevention by the individual, the family, and the community. These topics are discussed: (1) the reality of home care; (2) ingredients of mistreatment, including relationships, victimization by gender, self-abuse, and spouse abuse; (3) categories of mistreatment, including passive neglect, psychological abuse, financial abuse, active neglect, and physical abuse; (4) frequency of abuse; (5) why abuse occurs; (6) passive neglect and some causes of passive neglect; (7) forms of mistreatment other than passive abuse, including psychological abuse, financial exploitation, late-onset spouse abuse, active neglect, and physical abuse; (8) the prevalence and severity of elderly abuse; (9) prevention; (10) what individuals can do to protect themselves; (11) legal processes which transfer personal control to others; (12) public guardians, plenary and limited powers of guardians and incompetency; (13) precautions individuals can use to protect themselves against abuse; and (14) prevention of abuse by family members and the community. Case studies are included. Sources of assistance for the elderly are listed. A glossary of relevant terms is included. (ABL)

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TOWARDS PREVENTION

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Domestic Mistreatment of the Elderly —Towards Prevention

Richard L. Douglass, M.P.H., Ph.D.

Prepared for the
American Association of Retired Persons

This publication was prepared by Criminal Justice Services in conjunction with the AARP Women's Initiative, a major effort of the American Association of Retired Persons to address the special needs of mid-life and older women, many of whom are either the principal caregivers of older family members or at risk of becoming victims of mistreatment, neglect, exploitation, abandonment, or abuse in the domestic setting.

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Table of Contents

Introduction v

The Realities of Home Care 1

Setting the Stage for Mistreatment 2

- Relationships 2
- Victimization by Gender 3
- Two Types of Abuse Not Considered 3

What Are the Categories of Mistreatment? 3

- Passive Neglect 3
- Psychological Abuse 4
- Material (Financial) Abuse 4
- Active Neglect 4
- Physical Abuse 4

Frequency 4

Why Do Such Events Take Place? 5

Passive Neglect 5

Some Causes of Passive Neglect 6

Why Other Forms of Mistreatment? 8

- Psychological Abuse 8
- Financial Abuse or Exploitation 9
- Examples of Financial Abuse 9
- Late-onset Spouse Abuse 9
- Active Neglect 10
- Physical Abuse 10

Case Studies 11

Prevalence and Severity: How Bad Is It? 17

Intervention: Current Laws and Policies 17

Prevention: The Better Way 20

- Primary Prevention 20
- Secondary Prevention 21

What Can Individuals Do to Protect Themselves? 21
Some Legal Processes 22
Power of Attorney 22
Durable Power of Attorney 22
Deferred Durable Power of Attorney 22
Conservatorships and Guardianships 23
Public Guardians 23
Plenary and Limited Powers 24
Incompetency 24
Some Personal Dos and Don'ts 25
Preventing Other Types of Mistreatment 26
What Can the Family Do? 27
What Can the Community Do? 30
Asking for Help 33
Related Terminology 34
References 39

Introduction

Every now and then a "new" concern captures the public's attention. We're all familiar with examples: the dangers of acid rain or smoking, the wave of missing children, radiation from nuclear accidents. Concerns of this kind tend to be accompanied more by fanfare than by solid, reliable information. They also generate anxiety, which all too often leads to inappropriate laws and policies or to no action at all when some is needed.

This booklet explores an issue that has only recently begun to receive widespread public attention: the mistreatment or neglect of elderly people within the home.

Mistreatment of the elderly is an unusually sensitive problem because it involves such value-laden ideas as "home" and "family." The concept of home occupies a special place in American thought. We want to be seen as good, decent, caring, and generous people, and we often use our homes to project those images. As for our families, we tend to see them through lenses tinted with the rosy glow of warmth and affection.

But home and family are no more immune to violence than any other aspect of American life. During the past 25 years, for example, the image of domestic tranquility has been challenged by the realities of increasing child abuse and spouse abuse. To these we must also add the abuse or mistreatment of the elderly.

If we fail to address these problems of abuse, including violent mistreatment of the elderly, in all likelihood they will become more common during the years ahead. That's why this booklet examines what we know about mistreatment of the elderly by their families or by persons within their households. It also explores what we can do about it, both in terms of intervention and the long-range solution—prevention by the individual, the family, and the community. By laying out some of the facts and avoiding sensationalism and stereotyping, through this publication we hope to increase public awareness, stimulate appropriate action, and help prevent further victimization.

Horace B. Deets
Executive Director

The Realities of Home Care

Today, more Americans are living into older age than ever before. As the medical sciences have advanced, death has retreated, and our average life expectancy has increased by more than 50 percent since 1900. In 1910 only 4.3 percent of the American population was 65 or older; in 1980 that figure had grown to 11.8 percent, and by the year 2000 it will reach nearly 18 percent. Since 1950 the number of Americans age 85 or older has nearly quadrupled, from 600,000 to more than 2.3 million. And most older Americans now enjoy a better quality of life—in terms of health, housing, recreation, continuing employment and income security—than any other aging population in the nation's history.

Most older Americans also enjoy rich and interactive lives with their adult children or extended families. Many help younger family members in a variety of ways and, as they become more dependent, receive abundant assistance from their families in return. For those older persons who still live independently, the average family provides about 25 hours per week of special attention—shopping, laundry or dry cleaning, housecleaning, socializing, and so on. In short, the general pattern in American families is to be mutually available and helpful.

There are, however, less pleasant realities. For each severely disabled elderly person who lives in an institution, there are two who live with and depend upon their families. While many critics of institutional care might regard this arrangement as laudable, in-home care often imposes intolerable financial, physical and emotional burdens on families or other caregivers. As gerontologist Bernice Neugarten stated in 1980,"Large numbers of families. . . are going too far in caring for older people, stripping themselves of economic, social, and emotional resources to do so. In fact, one recent study showed that parent-caring is becoming a major source of stress in family life. The institutionalization of a family member usually comes only after the family has already done everything possible for them to do."

"The institutionalization of a family member usually comes only after the family has already done everything possible for them to do."
—Bernice Neugarten

In such cases the elderly are usually severely dependent and unable to care for their physical, financial or basic personal needs. "Severely dependent" is an ambiguous term, but usually it refers to those who have disabling health problems—Alzheimer's disease, stroke, other cardiovascular diseases, and fractures—and who require supervised care, either at home or in an institution. The most common cause of severe dependency is Alzheimer's disease, among the most devastating of the long-term diseases associated with aging. Alzheimer's victims must increasingly depend upon others as they progressively lose control of many physical functions. In these cases few families are prepared to provide adequate supervision or personal care without professional help. Many probably don't realize that the average length of home care for a severely dependent person who is over 70 is between five and six years.

Many families tend toward the belief that home care is the "best" alternative and they may offer it in response to a sense of duty or guilt, rather

than as a logical choice among potential options. Family members too frequently fail to understand or investigate those options before they are confronted with a personal crisis and initiate a long period of home care. It is not unusual for adult sons or daughters, age 50 to 70, to accept in-home responsibility for 85- to 90-year-old parents, uncles, aunts, or siblings. In many cases the caregivers are only slightly more able than the dependents.

Once home care has begun, the decision to discontinue it becomes extremely difficult to make.

Once home care has begun, the decision to discontinue it becomes extremely difficult to make. Acknowledging the need to institutionalize a frail dependent after a period of home care is commonly viewed as an admission of failure, and some caregivers tend to avoid or defer remedial action, even when the situation imposes an overwhelming burden on them. This situation has high potential for unintentional or passive neglect; however, it is also an opportunity for change and the prevention of such neglect or other forms of mistreatment.

Cost is another burden. Caring for a dependent older adult in the home or paying for such care in an institution can run from $19,000 to $35,000 per year or even more, enough to financially cripple many families. While federal, state, and local governments provide substantial medical, nursing and social services to the elderly, these programs fail to cover many of the costs.

Thus, at this point in our history with a large and growing aging population—even though it is generally healthy and vigorous—the prevalence of chronic illness, disability, and dependence in old age creates a situation we cannot ignore. It is in this social context that we most often confront neglect and abuse and it is also in this context that we must address intervention and prevention.

Setting the Stage for Mistreatment

Domestic mistreatment of the elderly is a phenomenon with identifiable causes and consequences. If we are to prevent such mistreatment, we must be aware of its basic ingredients.

Relationships—A wide variety of people are directly involved in domestic mistreatment of the elderly, and their living situations are often similar. There is usually a level of dependency between an elder and one or more younger adults, and the victim and perpetrator(s) generally live together, sometimes in the elder's own home.

Abusers can also include neighbors or landlords of an elderly victim who lives alone or relatives who exploit the victim's resources without having a truly dependent relationship with the victim. For example, the abuser may be a granddaughter who stops by her grandmother's home every afternoon to prepare an evening meal or administer a prescription medication. It may be a neighbor who removes trash each week or delivers groceries. A paid home health aide might spend an hour each day administering medications, preparing prescribed diets, or providing skin care for a bed-bound patient. These relationships are less substantial than many but they are also potentially suspect in cases of mistreatment.

Victimization by Gender—There is no clear evidence at this time that one sex is more vulnerable to victimization than the other, but there is speculation that elderly men are at *greater risk* of mistreatment than elderly women. While the average male does not live as long as the average female, he is more likely to be married or remarried and thus have a greater dependency on family members. In contrast, older women are better able to cope with the loss of a spouse than men and are more likely to live independently than widowers. In terms of reported victims, older women are more often cited simply because their numbers are so much greater.

Two Types of Abuse Not Considered—Two types of abuse are not included in this publication. One is "self-abuse," typically the negligent and potentially life-threatening actions of a mentally deteriorating older person who lives alone and is unable to care for himself or herself adequately but who resists outside help. On occasion, however, the self-neglecting or self-abusing individual is a competent person who fails to conform to community standards of conduct, hygiene, or maintenance of home or property. While self-abuse is a problem, it is quite different than mistreatment by others and discussion of it is not included in this study. Generally, self-neglect is not a prosecutable offense.

A second exclusion is the long history of spouse abuse that has been extended into old age. Spouse abuse crosses all racial, economic and age-group boundaries. Husbands or wives who have been abusive through long marriages are not likely to change their behavior at age 60 or 65. Spouse abuse that begins late in life, however, is considered part of the problem discussed in this booklet.

What Are the Categories of Mistreatment?

Since 1977, when the problem began to attract attention, researchers have suggested different ways to classify mistreatment. The classification offered here is consistent with most recent approaches.

The presence or absence of *motivation to cause harm* to an elderly person is a principal consideration that distinguishes some forms of mistreatment from others. Similarly, *active* rather than *passive* (or accidental) behaviors can provide the bases for separating classes of mistreatment. Finally, the *duration*—during the entire adult lifespan or over only the years of advanced age—is another way to separate one type from another. The principal forms of mistreatment all involve the personal *needs* of elderly people, particularly those needs that must be filled by others who are close to the victim. The needs may be physical, emotional, psychological or financial. Researchers have provided what may become the commonly accepted bases for defining different types of mistreatment.

Passive Neglect — The unintentional failure to fulfill a caretaking obligation; there is no conscious or willful attempt to inflict physical or emotional distress on the older person. Examples: non-provision of food or health-related services because of

the caregiver's infirmity, laziness, or inadequate skills, knowledge, or understanding of the necessity of prescribed or other essential services.

Psychological Abuse — The infliction of mental anguish. Examples: demeaning, name calling, treating as a child, insulting, ignoring, frightening, humiliating, intimidating, threatening, isolating.

Material (Financial) Abuse — The illegal, or unethical exploitation and/or use of funds, property, or other assets belonging to the older person.

Active Neglect — The intentional failure to fulfill a caretaking obligation, including a conscious and willful attempt to inflict physical or emotional stress or injury on the older person. Examples: deliberate abandonment, deliberate denial of food or health-related services, depriving of dentures or eyeglasses.

Physical Abuse — The infliction of physical pain or injury, or physical coercion (confinement against one's will). Examples: slapping, bruising, sexually molesting, cutting, lacerating, burning, physically restraining, pushing, shoving.

Frequency

Some forms of mistreatment are more common than others but . . . no major research has been conducted into their magnitude or severity in the United States or elsewhere.

Some forms of mistreatment are more common than others, but as of 1986 no major research has been conducted into their levels of magnitude or severity in the United States or elsewhere. This issue of actual prevalence will evade us as long as states, cities, and other units of government use different definitions and reporting methods. Similarly, the true frequency of various kinds of mistreatment or the rates, cannot be assessed until there are compatible, reliable, and ongoing records. As the country becomes more responsive to mistreatment of the elderly, and as social, health and criminal justice systems learn how to handle cases, improved measurements may become possible.

Since 1977 most research has found that the *relative* frequencies among the categories of mistreatment have been consistent. This finding is supported by people who work with abused or mistreated older persons on a regular basis. Passive neglect is probably the most widespread form, followed in order by psychological abuse, material abuse, active neglect, and physical abuse.

Overall, while there may be hundreds of thousands of victims, only a fraction are being physically abused. Any form of mistreatment of the vulnerable elderly can result in severe harm and even life-threatening conditions; therefore, physical abuse is not necessarily more "severe" than passive neglect or psychological abuse.

Most mistreatment cases are not intentional, but many are, and they involve criminal behavior resulting from greed, psychotic conditions, or other factors. Some states have enacted legislation defining certain forms of abuse as felonies that require prosecution. The issues of prevalence and severity are discussed in greater detail later in this booklet.

Why Do Such Events Take Place?

As noted, research into the mistreatment of older persons in their homes has been limited, and it is useful to remember that the causes of child abuse, neglect, and other family violence are poorly understood even after many years of intensive examination. Despite these drawbacks researchers are able to offer some tentative findings.

Individuals and family groups are extremely complicated, and it is unlikely that a single factor is responsible for mistreatment. Different types of mistreatment are probably caused by different combinations of the personal traits of the people involved, household finances, the interpersonal relationships that have developed over time, external events that affect the household, and similar factors.

There is some evidence that middle-class families suffer the greatest stress and fatigue in caregiving situations. Unlike affluent families, middle-income families cannot afford outside help. And, middle-income families do not normally display the intergenerational dependence that is common in lower-income families.

Passive Neglect

Passive neglect is the most commonly and clearly understood form of mistreatment. In most situations it is the tragic result of well-meaning family members, friends, or other persons who assume the care of a frail and dependent older person but who are incapable of meeting that person's needs. They may not be up to the task for many reasons. The home care of a frail adult is more taxing than most people think. The physical, emotional, and financial costs can be enormous, particularly when the dependent older person is bedfast, incontinent, or the victim of a long-term, behavior-changing illness. It is awesome to consider individuals and families who undertake intensive personal care of a very old and frail loved one; the burden, duration and financial costs are all but overwhelming. One or two adults may try to carry on the same functions as performed by the entire staff of a home for the aged. But if one of the principal caregivers suffers a stroke, heart attack, crippling arthritis, fracture, or some other physical crisis, his or her ability to continue the level of care can change drastically. Poor care or neglect can result.

In most situations, passive neglect is the tragic result of well-meaning family members, friends or other persons who assume the care of a frail and dependent older person but who are incapable of meeting that person's needs.

Part of the preparation for home care, in addition to learning specific skills and techniques, is to understand the duration of any major health problems and to appreciate the commitments of time that may be required. Concerns that may initially seem trivial can become major issues as caregivers are

forced to put aside retirement plans, vacations, or other expectations to care for a frail, elderly loved one.

Some Causes of Passive Neglect

The following describes the principal causes of passive neglect. No single factor should be viewed as sufficient to bring about an overwhelming problem, but combinations of two or more factors could very well do so.

- The caretaker's physical, emotional, or financial status can suffer if he or she is vulnerable to stress, long-term demands, or unexpected exertion.
- The dependent's physical, emotional, or financial status affects the level of ongoing care to be provided and the ability of the older person to contribute in any way to the household.
- All human relationships are fragile. Even during the best of times members of close-knit families who live together go through periods that require extra tact and understanding. In a situation in which an elderly person is dependent for essential personal care and supervision into the indefinite future, relatively minor problems can reach crisis proportions. In such circumstances caregivers must be emotionally prepared for the inevitable tough times that will test their commitment and affection.
- Decisions about how much or what kind of supervision or personal care to provide for a dependent relative or friend are almost always more complicated than they first seem to be. There may be alternatives that are economical and that offer quality and convenience but that exceed the capability of household caregivers. Knowledge of these alternatives can lead to sounder decisions regarding responsibilities and the quality of life for the caregivers and their wards. If caregivers choose without adequate knowledge of alternatives, learning about these alternatives at a later time can lead to resentment or anger.
- The personal intimacy inherent in home care of dependent elderly can exceed that of any relationship other than marriage or the care of very young children. The maintenance of hygiene and other aspects of care involve a mutual desire to avoid embarrassment or other negative reactions. If this desire is absent, the resulting conflict of attitudes and beliefs can break down the relationship and lead to neglect or avoidance. If a caretaker finds a situation embarrassing or degrading, he or she cannot perform the tasks required over an extended period without a high potential for neglect. If the caregiver ignores the dependent's dignity and modesty, the dependent's self-esteem can be severely damaged.
- The belief that "all nursing homes are bad" was found to be common in a Michigan study by the author and it is likely this belief is widespread. When a family's decision to provide home care to a frail and impaired older person is based principally on an aversion to placement in a nursing home it can indicate a lack of sophistication and knowledge that could lead to passive neglect. Home care is not necessarily superior or even

equal to nursing home care for patients needing high levels of care. Families who avoid placement, while well-meaning, may be unintentionally shortchanging their loved ones and themselves.

- Home care requires important skills: the ability to clean an adult who has little mobility; the ability to turn and bathe a bed-bound person without causing harm; the ability to protect one's self while caring for an adult. These abilities are neither obvious nor instinctive. Without such skills, passive neglect is virtually inevitable as the recipient of care grows more frail over time. Prior to accepting the responsibilities of caring for someone at home, potential caregivers should assess their skills and knowledge and, if necessary, seek assistance from experienced family caregivers or professionals.
- When a frail and dependent elderly person moves into the home of family members or friends (or becomes frail while living there), major changes can occur in the functioning of the home and the relationships of everyone in it. Young children, house maintenance, work schedules, and school or community roles can directly compete with the demands of extended personal care. If these competing demands become dominant, the care of the dependent older person can suffer—not because of intent but because all households have limited resources.
- The physical layout of the home can be inappropriate or inadequate for continuous personal care. The location of bedrooms and baths, space for privacy for all household members, barrier-free or minimal barrier access, and other physical qualities of the building can either ease the burden of home care or increase the level of effort beyond the caregivers' capabilities.
- If the caregiving household is already unstable because of interpersonal conflicts, inadequate financial resources, or physical or emotional problems, the normal rigors of home care will not improve the situation. Unexpected unemployment, marital conflicts, or other problems can destroy a family's capacity for providing home care. When this happens, passive neglect can result.
- The isolated family providing care may be neglectful because many of the needs of the dependent older person can only be met with the direct or indirect assistance of people and organizations outside the home. The ability to call in a supportive neighbor or friend to provide temporary respite from in-home caretaking can mean the difference between adequate care or neglect. Neighbors, other relatives, and friends can assist with shopping, transportation, home maintenance and other demands that either will be neglected or will compete with the needs of the recipient of care. The visibility of the family and its caregiving role to the outside world is an added protection against unintentional neglectful practices.

Stated differently, these potential causes of passive neglect become a list of important considerations for the family that contemplates providing home care to a dependent aged adult. When combinations of the above factors suggest that proper care will be inadequate or absent, passive neglect can be the non-surprising result.

Why Other Forms of Mistreatment?

All other forms of mistreatment include harmful intent plus signs of serious psychological deficiency in the abusive caregiver. *Psychological abuse, financial exploitation,* late-onset *spouse abuse, active neglect* or *physical abuse* are not necessarily attributable to an overtaxed, but well-meaning caregiver. These problems suggest an active role for the perpetrator who may be motivated by conflict with the recipient of care or by social pathological problems.

Psychological Abuse

Psychological abuse is not necessarily associated with a dependent-caregiver relationship. In fact, *some abusers may be dependent upon their victims.*

Psychological abuse is not necessarily associated with a dependent-caregiver relationship. It is quite possible for victims of this form of mistreatment to be fully independent. In fact, *some abusers might be dependent upon their victims.* Adults who are dependent upon an elderly parent, for example, might resent their own lack of independence or ability to provide for themselves. Certain longstanding, unusually emotional ties with a parent are known to be barriers to an adult child's ability to establish mature relationships with spouses or other adults. Financial dependence upon an aging parent can also be a source of embarrassment in our society which places a high value on individual independence.

Psychological abuse is generally associated with a poor relationship between victim and perpetrator. Psychological abuse is intentional but it may be intensified by emotional crises such as unemployment, a change in the condition of the older person, or alcohol abuse. Whatever the cause, psychological abuse can produce serious problems for the victim, among them depression, isolation, reduced self-esteem, and self-destructive tendencies. But since the mistreatment is rarely exhibited in public places, others in the family or non-relatives who are providing care are not likely to grasp what is happening and they may blame the depressed or withdrawn victim for his or her own emotional state. When an otherwise self-sufficient older person becomes depressed or isolated, cries frequently, or loses interest in formerly important community or family activities, the cause may be the treatment given (or not given) by an adult child, another relative or a caregiver. As noted above, perpetrators may rely on their victims for money, housing, or personal maintenance. Resentful of their dependency, these individuals—many with personal problems—can threaten, intimidate, or harass the person they depend upon. As in active neglect, psychological abuse is increasingly likely when the victim is physically or socially isolated, unusually demanding, or agitated.

Financial Abuse or Exploitation

Most authorities agree that greed is the principal cause of financial abuse or exploitation. Theft or mismanagement of an older person's resources is clearly motivated behavior. While older persons need not be wealthy to be victims of this form of mistreatment, some evidence suggests that affluent elders are more likely to be exploited. Numerous cases in the literature cite both affluent and marginally poor older persons whose resources are stolen or used for the benefit of others. Less affluent victims, however, are more likely to be psychologically or physically abused while they are being financially exploited.

Financial abuse and exploitation are forms of theft. But criminal fraud and larceny by family members or home caregivers are rarely reported to police or prosecuted because victims are reluctant to bring criminal charges against relatives or friends for fear of retaliation or loss of the only support system they know.

Examples of Financial Abuse

An adult daughter in Florida "helped" her aging mother by cashing, depositing, and managing all of the elderly woman's income. The daughter paid all bills and purchased all her mother's groceries and clothing from her mother's checkbook. The daughter also paid her own utility, telephone, and gasoline credit card bills from her mother's account. The elderly mother never understood why necessary household repairs were always "too expensive" until she had a neighbor examine her checkbook.

A 75-year-old man, widowed for three years, was asked by his son to move into the son's home. In return, the son insisted that his father transfer all his resources, financial assets, and beneficiary designations to him. The assets included ownership of two small businesses, three homes, and substantial stock and other investments. When the father became frail following a stroke, his son placed him in a nursing home as a pauper, where he was supported by Medicaid until he died six months later.

Late-Onset Spouse Abuse

Late-onset *spouse abuse* has been separated from psychological or physical abuse because the dynamics that lead to late-onset spouse abuse differ from other causes of abuse.

Most spouse abuse has little or nothing to do with the aging of its victims. It has been part of a marriage for many years, and many victims endure abusive treatment throughout their adult lifetimes. However, there are cases in which an abused wife or husband, upon the aging or disability of an abusive spouse will become abusive to "get back at" the offender. Most spouse abusers at any age are men. Late-onset spouse abuse is often associated with alcohol or drug abuse, unemployment, post-retirement depression, loss of self-esteem,

Most spouse abuse has little or nothing to do with the aging of its victims.

the perpetrator's history of being an abused child, or an unusual level of violence in the home. Abused spouses who have endured such treatment for many years are usually isolated and many have little contact with a social network or close relatives.

Active Neglect

Active neglect includes the deliberate withholding of services, materials, or intangibles such as contact with friends. It is often linked to a desire to cause pain or suffering or to inflict punishment. Active neglect is a form of *abuse*—a combination of deliberate behaviors and consequences that are caused by diminished delivery of care, materials, or services. The reasons for active neglect can include the same elements that cause passive neglect—all suggesting a household that may be at or near a breaking point. But active neglect also includes a decision, explicit or implicit, to *not* provide for a dependent older person, usually with some form of benefit to the provider. The caregiver who practices active neglect may be attempting to relieve the family of the burden of caregiving by forcing the older person into a health care facility. Or, he or she may be trying to protect the family from social embarrassment. Some who actively neglect may not be aware of how severe the consequences of their actions can be. Some actively conspire to mistreat their victims. Both passive and active neglect can occur only when the victim is dependent upon the caregiver. Active neglect is likely to be associated with victims who are socially or physically isolated from the witnesses who could prevent this form of mistreatment.

Physical Abuse

Physical abuse, the form of mistreatment most frequently discussed in public, is statistically the least validated.

Physical abuse, the form of mistreatment most frequently discussed in public but statistically the least validated, is also related to the personal or situational problems of the adults involved. It is frequently associated with alcohol abuse by the victim or perpetrator (or both). It is unclear whether alcohol abuse is a cause of violent behavior or its result, but its presence in the home probably increases the frequency and severity of assaults.

As with child and spouse abuse, the signs of physical abuse of the elderly rarely come to the attention of the medical or criminal justice systems. Social stereotypes of frail or feeble older persons are often used to explain cuts, burns, fractures, or bruises actually caused by physical abuse, and if medical, nursing, and law enforcement authorities are not sensitive to the possibility of physical abuse, they are likely to accept such explanations. Because society's consciousness of mistreatment of the elderly is very low, abusers are protected by the improbability of anyone's suspecting their criminal behavior. Victims of physical abuse are usually isolated, and their isolation may be self-imposed because they are ashamed of or embarrassed by the signs of mistreatment.

Adult sons who have always depended upon their mothers, fathers, or other older relatives have been most frequently identified as physical abusers. This

role-relationship is not as common in other forms of mistreatment, and thus, physical abuse must be viewed somewhat differently. Physical abuse is usually accompanied by neglect and psychological abuse; combinations of causal factors lead to combinations of mistreatment.

Case Studies

The following examples of domestic mistreatment of older people occurred in Michigan, Ohio, and Illinois between 1980 and 1985. The names are fictitious, but all other information is factual. Two cases have been selected from each major type of mistreatment to demonstrate the variety of circumstances, causes, and characteristics that can occur.

Passive Neglect—Case #1

Bill and Arleen, married for 26 years and childless, moved from a large city to a small suburban community after Bill retired from a career in a public utility. Bill, age 68, was considerably overweight due, he said, to Arleen's cooking. At 260 pounds and 5′7″ tall, Bill was more than twice Arleen's weight and three inches taller. After 14 months in their new home, Bill suffered a heart attack, and his doctor ordered him to take it easy for six months. Arleen assumed she would care for all of Bill's needs, but three months later he developed a series of respiratory infections and became weak and unable to shift positions in the hospital bed they had purchased. During Bill's fourth month in bed, Arleen and a neighbor, while turning him onto his side, discovered three large bedsores on Bill's shoulders and left buttock. Bill was taken to the hospital, treated as an outpatient, and returned home that afternoon. At this point, Arleen realized that she needed help in caring for Bill. She had never been instructed by Bill's physician or any hospital personnel about skin care or the problems associated with bedfast elderly. She secured a home health aide for three hours each day and enrolled in a course on home care. Bill was placed on a restricted diet designed to reduce his weight and he lived for two years at home prior to a second, fatal heart attack. Arleen then became a volunteer home health aide and worked with the local hospital to identify elderly family members who had been forced to assume home-care responsibilities for an invalid or frail adult.

Passive Neglect—Case #2

Mr. and Mrs. A. retired from assembly-line jobs, five years after coping with the deaths of three of their parents. The surviving parent, Mr. A.'s mother, a severe diabetic, was living with them. The senior Mrs. A. had suffered three strokes before the couple retired. Three months

after their retirement, she suffered a fourth stroke that left her completely dependent upon others for feeding, hygiene, and all personal care. Although mentally alert, the elder Mrs. A. could not speak and was unable to write. She became very depressed and lost interest in food. Five months after his r ther's fourth stroke, Mr. A. died of a stroke. Mrs. A., Jr., vowed to continue caring for her mother-in-law alone. During the next three years Mrs. A., who was 67, became depressed, unkempt, and isolated from formerly close friends and relatives. When her oldest daughter visited, three years to the day after her father's death, she found the elder Mrs. A. crying in her bed in her own body wastes, with spoiled food and insects throughout the bedroom. The younger Mrs. A. was in the family room sleeping in front of the television. She awoke and explained that she couldn't take care of her mother-in-law any more and had stopped trying three days earlier. Mrs. A., senior, was placed in a local nursing home and survived in an alert non-depressed state for six years. Mrs. A., junior, moved into her daughter's home and died within ten weeks.

In both of these passive neglect cases, the caregiver was unprepared emotionally or physically for the task of sustained home care and lacked the intellectual and practical knowledge to provide it.

Active Neglect—Case #1

Bill and Beatrice cared for Beatrice's mother, Mabel, who was 81, confused, and unable to care for herself. Mabel wandered when unsupervised and attempted to do things that had caused problems; for example, she once took all the encyclopedias from a bookshelf and put them into the food freezer. Reacting to the difficulty of taking care of Mabel, who was physically healthy and strong, Bill and Beatrice emptied Mabel's room except for a mattress and a blanket and locked Mabel inside the room for prolonged periods during the day, and all night, every night. One day a neighbor heard Mabel calling for help from a window and called the police. A police officer, accompanied by a county social worker, found Mabel in her room sitting in a pool of urine and singing a childhood song. Bill and Beatrice stated that they could not supervise Mabel in any other way and that they cleaned her daily and disinfected her room twice each day. Bill and Beatrice refused to pay for home-care assistance and denied responsibility for the costs of a nursing home or an alternative supervised living placement. Public authorities placed Mabel on public assistance and enrolled her in a specialized long-term care facility. Bill and Beatrice visit her weekly.

Active Neglect—Case #2

Walter had lived with his 52-year-old son, Milan, since his 73rd birthday and the sale of his farm. Walter and Milan agreed to pool their assets and incomes and live together. Walter required several medications daily for a variety of disorders but he had limited health care insurance and no insurance coverage for prescription drugs. After four years, Milan convinced him that most of the medications were unnecessary expenses and that he should buy a substantial life insurance policy. Walter's health deteriorated and he required hospitalization during the next five months. When he was discharged from the hospital with a list of prescription medications, his son refused to buy them and also failed to take his father to medical appointments. Walter's health rapidly deteriorated and he was admitted to a Veterans Administration hospital. Walter's complaint to a nurse regarding his care at home led to the intervention of a hospital caseworker who was able to inspect Walter's financial papers. Walter was the co-signer on a savings account he shared with his son, and he withdrew 50 percent of his cash savings and donated the funds to his church. Walter also named his church as the beneficiary on his life insurance policy.

These cases of active neglect demonstrate that such mistreatment is usually caused by inept or unimaginative caregivers who don't always recognize that their form of home care is harmful. Some want to gain control of resources. Walter's son, for example, wanted to acquire as much of his father's estate as possible, so he refused to buy "unnecessary" medications or medical care. Bill and Beatrice did not want to pay for private supervised care for Mabel even when it became obvious that they were unable to adequately care for her. Both cases include elements of greed and lack of sincere concern for the well-being of the elderly dependent relative.

Verbal and Emotional Abuse—Case #1

Alice, 54, and her mother, Louise, 77, began living together after Alice's husband divorced her. They shared household expenses equally and had ample money for vacations and visits to distantly located children and grandchildren. Alice took a part-time job at a local accounting firm. The job, her first since her first child was born 34 years earlier, became the center of her life. Soon, her work and social life expanded to the point that she accepted full-time employment and began to spend several nights per week away from home with men she met through her work. Alice's mother disapproved of her dating and was jealous of activities that used time Alice previously had devoted to mother-daughter shopping and travel. Alice no longer wanted to live with Louise but did not have the courage to say so.

Instead, she began attempting to convince Louise that she was "senile" and belonged in a senior citizens' housing project. After several months of listening to lectures about how forgetful and accident-prone she was, Alice's mother applied for an apartment at the senior citizens' center. By the time she was able to move to the center, her relationship with Alice was so seriously damaged that Alice did not visit her for more than six months. Largely due to her depressed condition and isolation, Louise became neglectful of her own well-being and had to be admitted to a hospital. She died seven months after she moved out of her daughter's home. None of the other children or grandchildren was told of the problem or of the grandmother's move until after she was in the hospital.

Verbal and Emotional Abuse—Case #2

Bill, an 84-year-old victim of Alzheimer's disease, lived with his only living relative, a great-nephew, Jerry, who was married and had three adolescent daughters. Although "Uncle Bill" was Jerry's favorite uncle, he had never developed a close relationship with the nephew's wife or children. Jerry had insisted that Bill move into the family's home when his doctor said that it was not safe to live alone. Although the nephew initiated the move, his family shouldered most of the subsequent accommodations. One of the girls' rooms was given to Uncle Bill and two of the daughters were forced to share a room after always having had their own private spaces. Their mother found it impossible to leave home during the day and greatly resented the loss of social and civic activities. At about the same time, Jerry was promoted and had to spend more time away from home. The family soon began to express their resentment to Bill, whose occasional lucid moments became frightening episodes of accusation, name-calling, and threats. During one of these episodes, Bill became so frightened that he ran from the house, only to become confused and disoriented after walking into a strange neighborhood. Bill was lost for three days before he was identified by police and returned home. A city caseworker interviewed the family and recommended that Bill be placed in a specialized housing development for victims of Alzheimer's disease and associated problems. With special treatment, in a month Bill was lucid more frequently and for longer periods than he was when living in the family home.

These cases of verbal and emotional abuse indicate that family ties are not always the best credentials for home care. Individual and family needs, if not carefully considered prior to a commitment to home care, can become major causes of resentment, which is expressed as verbal or emotional abuse. Older people are frequently more vulnerable to suggestion and more willing to degrade their own self-perceptions than younger people, many of whom receive

positive feedback from peers and others. Infirmity and dependency can so limit an older person's ability to reject the excuses for abuse that it can soon become the older person's reality. When the decision to live with younger relatives is based upon a crisis situation (as with Alice after her husband rejected her and her mother embraced her), the older person often assumes that a relationship that has been "on hold" for 20 or more years (mother-daughter, for example) simply will resume. Such situations are easily turned into disappointing and even hazardous confrontations if there is a lack of maturity and planning by everyone involved.

Physical Abuse—Case #1

Mrs. W., a widow, lived in a small townhouse in a large city. Her 50-year-old bachelor son, Fred, had lived in the family home all his life and like his father, who died at 56, became an alcoholic in early adulthood. Mrs. W., who was diabetic and obese, had a substantial income from stocks, Social Security, and the rent that a small apartment in the building provided and she never pressured her son to work.

Fred had little life of his own beyond drinking. As his small peer group became involved in their families and other interests, he became convinced that his life was ruined because of his mother's "hold" on him, but he made no effort to become independent. His mother excused his behavior, blaming it on his drinking.

When she was 84, Mrs. W. was hospitalized for fractures of the hip and lower jaw. Prior to this she had been examined five times for fractures and bruises on the face and torso. All of these injuries had been attributed to falls or "clumsiness." But they were actually caused by her son hitting or pushing her, usually when he was drinking. During her hospitalization Fred, who was co-signer on all of her bank accounts, withdrew most of her cash, sold all her stocks, and deposited these funds in new accounts in his own name. When Mrs. W. was discharged from the hospital she found that her son had taken most of her assets and burned her furniture. He told her to "hurry up and die."

Mrs. W. lived for four more years as a prisoner in her own home. The case came to light when an acquaintance complained to a neighborhood priest that Mrs. W.'s son wouldn't let her out of the home. Mrs. W. was removed to a nursing home and died shortly after admission. An autopsy revealed that she had been beaten regularly and suffered multiple fractures up to the time that she was removed from the home. Without witnesses or evidence, no charges were brought against her son, who continued to live in the home.

Physical Abuse—Case #2

Allen, a retired railroad worker, age 66, lived two miles from his parents who were both 85 years old and reasonably healthy. They had hoped to stay in their own home until they died, but it was more than two miles from the nearest shopping center and neither parent could drive because of poor vision. So the couple decided to move into a small apartment two blocks from Allen's home.

Allen was concerned about his own family's financial future and his difficulty in meeting the payments for an expensive home and tuition for three children still in college. To all appearances, Allen was a model husband and father but in reality he was a long-term spouse abuser who had also been arrested twice on charges of assault. In both cases the charges were dropped by the victims—neighbors who had tried to come to the aid of Allen's wife while he was abusing her. Allen's wife also refused to file charges against him or to consider divorce or separation. Allen had been abused as a child by both of his parents, as were all four of his siblings. The parents, however, paid for his college education and provided the down payment for his home.

With his parents living closer, Allen's wife encouraged him to visit daily. This resulted in Allen visiting his parents during the monthly financial crisis which plagued his household. Three months after his parents moved into their apartment Allen asked them for a large sum of money to help him reduce his indebtedness. When his father said the money wasn't available, Allen beat him and threw his mother through a glass door. There were no witnesses and no charges were filed. After three similar violent assaults, Allen's mother was hospitalized with a cerebral hemorrhage. An emergency room nurse reported suspected domestic violence and after a police investigation Allen's father filed assault charges. Allen was jailed for 90 days. During that time, his parents moved to a senior citizens' apartment complex and obtained a restraining order that prohibited Allen from visiting them alone.

These cases of physical abuse indicate the complexity of such extreme forms of mistreatment. Physical abuse is generally associated with other forms of mistreatment such as financial exploitation, verbal or emotional abuse, or active neglect. Physical abuse can also plague succeeding generations. Some authorities contend that abused children are more likely than others to become parent abusers. Physical abuse is associated with psychopathic behavior, emotional disorders, drug abuse or alcoholism, and other sociopathic characteristics. Physical abuse is always considered to be criminal behavior regardless of extenuating circumstances.

Prevalence and Severity: How Bad Is It?

It is difficult to estimate the prevalence of domestic mistreatment of the elderly or its levels of severity. Only in recent years have some states begun to treat certain forms of abuse of the elderly as a crime instead of a "social problem," and the legal definitions of reportable abuse or neglect vary widely. Even researchers have yet to agree on their definitions. The likelihood of a case being reported depends upon state laws, local police practices, social services assistance levels, prosecutorial or court-related activities and the people involved. Mental health, medical, law enforcement, and other professionals all view the "problem" differently.

Only in recent years have some states begun to treat certain forms of abuse of the elderly as a crime instead of a "social problem."

In *Elder Abuse: A National Disgrace*, the most recent report on this problem by the House Select Committee on Aging, Representative Claude Pepper of Florida, Chairman of the Subcommittee on Health and Long-Term Care, states that "over 1,000,000 older Americans are physically, financially and emotionally abused by their relatives or loved ones annually." While the report provided no information on the number of first-time cases, other studies suggest that as many as 95 percent of the cases reported involve repeat offenses. One thing is certain: the vast majority of cases in all likelihood don't come to the public's attention.

It is also certain that the problem will grow as the older portion of the population increases and that there will continue to be thousands of cases for which no help is available.

At the individual case level, the severity of mistreatment is usually gauged by the extent of harm done to an individual. Stories of criminal assault, rape, forced confinement, torture, homicide, theft, threat, harassment, abandonment, and enforced isolation are common in both the scientific and popular press. But while these "horror stories" raise our consciousness, they don't help us understand the suffering involved. As Shakespeare said in *King Lear*, "How sharper than a serpent's tooth it is to have a thankless child," so too are an older person's shame and suffering compounded when the mistreatment is perpetrated by his own child or a person he has loved and trusted.

The emotional and psychological consequences of all forms of mistreatment can be life-threatening. Injuries requiring medical attention, while clearly serious, may be no more painful or life-threatening than intimidation, insults, and exploitation on a continuing basis. For some, active neglect can be so damaging that it leads the older person to long for death. Our responsibility is to recognize the pain and despair in any form of mistreatment and to act to eliminate its causes.

Intervention: Current Laws and Policies

When a major new social issue comes to light, the public's usual response is to call upon existing systems—the police, social services, legislatures, prosecutors, the courts—to intervene to "solve" the problem. The following section describes typical current responses to the problem of elderly mistreat-

ment. Unfortunately, none of these methods of intervention is an appropriate way of *preventing* the mistreatment of the elderly.

In response to the first research on abuse and neglect of the elderly and after considerable encouragement by the federal government, most of the states and the District of Columbia have enacted some form of adult abuse or protective services laws. These statutes usually provide for intervention, advocacy, and mandatory reporting of suspected abuse or neglect to a specific agency, some at the state level, but most often at the county or city level. These laws generally require licensed professionals to report, although different states specify different professionals. For instance, in one state, physicians are *not* required to report instances of abuse, while nurses, pharmacists, teachers, and social workers *are*. After a report is received, the designated agency usually is obligated to investigate within two to four days. If the mistreatment is verified, the investigation may involve the police, courts, social service or other community agencies, or diversion from the criminal justice system. In cases of clear and imminent danger the police or sheriff may get the first call for services. When the form of mistreatment is passive neglect, those involved can begin to receive a multitude of services, such as financial assistance, physical and mental health assessments, home maintenance, home health care, meal preparation, counseling and other interventions.

When criminal acts or intent are revealed, however, the victim usually must file a complaint against the perpetrator if criminal sanctions are to be employed. If the victim files a formal complaint, police and court actions can result, in addition to possible direct assistance to the victim. But adults judged to be mentally competent have a right to refuse assistance, and they can decline to sign criminal complaints. Many do, citing fear of reprisal by the perpetrator, fear of abandonment, and embarrassment.

Some states have no adult protective services laws to deal with mistreatment, which puts some of the burden on the criminal laws. If the mistreatment is passive neglect or is not severe enough to gain the attention of law enforcement officials, these states can offer little to the victims. In 1985 the House Select Committee on Aging estimated that only about 20 percent of all cases are reported, leaving four out of five cases unknown to police or social service agencies.

When criminal behavior is involved, professionals must be able to recognize the signs of mistreatment.

Law enforcement, medical, nursing, health care, social work or other professionals in the community are the first line of defense for victims of neglect or abuse. When criminal behavior is involved, even if no mandatory reporting law is in effect, professionals must be able to recognize the signs of mistreatment so they can be alert to the possibility of it in households with elderly residents. If these professionals are unfamiliar with at-risk family settings, they may overlook life-threatening signs even though they are trained to provide help.

There is growing evidence that greater public awareness—as in "Neighborhood Watch" programs and similar community self-help efforts—can help communities expose mistreatment, establish higher levels of intolerance of mistreatment, and provide support and assistance to families

that need help. Too often families caring for frail elderly are isolated from their communities. Through efforts to reduce such isolation, communities may be able to prevent neglect or abuse in some cases and bring appropriate attention to situations in which an aging neighbor is at risk.

New attention is being given to developing coordinated efforts to respond appropriately to reported cases of mistreatment. Increasingly, such efforts attempt to provide legal advocates for elderly victims who do not have personal counsel. Without coordination, single cases are often approached by agencies or service providers on a piecemeal basis and other cases are simply not reported or assisted.

Reporting and investigation can lead to actions ranging from assistance with the care of a homebound older person, to some form of respite for the caretaker, or to legal or criminal sanctions. But each intervention, however well-designed and intended, can cause new problems. For instance, a physically abused elderly woman could be unwilling to leave her home (in some cases, also the home of the perpetrator) and could also be unwilling to sign a complaint against the offender. Protective services workers or court officials, who are aware of such unwillingness, might rule that voluntary exposure to a continuing life-threatening situation is evidence of mental confusion. As a result, they may declare the victim incompetent and have him or her removed to a nursing home or another type of sheltered housing.

If a victim is lucid and can clearly articulate a preference to remain at home, other options may be available, but it may take a legal advocate (perhaps a court-appointed guardian) to find the appropriate alternatives. Restraining orders and court supervision of cases can enable or facilitate law enforcement or social services attention during a specified period without the need for permanently terminating the victim's rights and thereby contributing to the crisis. In some cases this degree of intervention is sufficient to stop the abuse. It is not usually advisable to seek guardianships for victims of mistreatment immediately, as a first course of action, because especially in the stress of the moment, fear and other strong emotions can mask the victim's true capabilities for self-determination.

Not all of the foregoing assumptions apply in many parts of the United States. Unfortunately, legal, law enforcement, health or social services specially designed for the elderly are neither uniformly available nor of uniform quality in the United States. In some jurisdictions there have been serious violations of the ethical goals to do no harm and to seek the least restrictive alternatives to imposing state control on the competent but frail older person. Important constitutional issues of privacy, due process, and the right to self-determination still remain unresolved. While we are increasingly aware of the need for services to respond to the graying of America, adequate resources are unlikely to be available in the near future.

With only 20 percent of the estimated cases of mistreatment receiving professional attention and with serious economic and political constraints on the growth of services, it is clear that strategies to deal with domestic neglect and abuse of the elderly must include more than reporting and intervention. *Prevention* is the key to the problem. As with any form of domestic abuse

Prevention is the key to the problem.

and neglect, some cases will defy the most sophisticated strategies for prevention, and will always require fast and certain intervention. We do have options for prevention, however, as individuals and as a society. If we choose to support efforts to *prevent* domestic neglect and abuse of the elderly we stand to gain economic and material benefits. Equally important, we will be able to face the community of nations as a society that seeks to realize a high quality of life and individual dignity.

Prevention: The Better Way

The first important question is: What is to be prevented? To answer it we have to think of mistreatment as the end result of many contributing factors. Passive neglect is generally the consequence of well-meaning but inadequate care for a vulnerable and dependent person. In most cases, the caregivers are initially quite capable of meeting the needs of the dependent, but they are eventually overwhelmed by increasing frailty, additional disabilities, their own illness or impoverishment, or a combination of these problems. When this happens, neglect can be the first consequence, followed by other reactions to frustration or fatigue, including verbal or emotional abuse or even physical harm. The time to think about prevention is not when the caregiver's ability begins to be inadequate; this may be too late. Prevention planning requires making alternative plans in advance for providing care, thereby setting the stage to prevent both victimization and culpability. In situations in which the victim is not entirely dependent, advance planning can also reduce the vulnerability to abuse.

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There is substantial evidence that longstanding conflicts among family members can lead to abuse and intentional neglect. Other causes include greed, competition among adult children for shares of the expected estate, a desire to "save" the parents' estate by withholding necessary services to the parents, physical violence associated with an emotional, psychotic, or sociopathic condition, and a longstanding family history of violence. In such cases, prevention is more difficult to plan or achieve.

Primary Prevention

The most successful prevention efforts eliminate the probability of mistreatment. This level of prevention, referred to as *primary prevention*, is possible only when the causes of a specific type of mistreatment are clearly understood and predictable. These causes can include the physical disability of the caregiver, exhaustion of a family's financial resources, a history of family violence, known alcohol abuse by the caregiver or the dependent, a known emotional or psychiatric problem or previous criminal behavior by the caregiver. If there are combinations of causes, the chances for mistreatment increase.

Because of the value we put on privacy, few government or private service agencies have the information they need to anticipate situations in which mistreatment *might* occur. For example, criminal records do not contain

detailed family data and no public records include lists of frail elderly who are at risk for one reason or another. Therefore, much of the responsibility for primary prevention rests on individuals who are acting in their own best interests. Government and other community resources can educate the public, help individuals establish methods of self-protection or reduce opportunities for abuse, and intervene when mistreatment occurs.

Secondary Prevention

If intervention becomes necessary it can include a plan for preventing further mistreatment. This level of prevention is called *secondary prevention*. Aside from educational programs, most government or agency-initiated efforts are forms of secondary prevention. All case-finding activities, as the name implies, are secondary prevention programs that can only hope to prevent *further* mistreatment. Secondary prevention efforts can include initial recognition of cases with low levels of damage and the introduction of counseling, training, personal assistance, respite for caregivers, or crisis intervention to protect the life or property of a victim.

Prevention activities can be initiated for two fundamental purposes—to limit or eliminate the risk of someone's becoming a victim of domestic mistreatment, or to limit or eliminate the risk of someone's becoming neglectful of or abusive to another person. Each of these purposes is discussed below.

What Can Individuals Do to Protect Themselves?

Not everyone is willing or able to anticipate his or her own physical, mental, or financial deterioration or the possibility of becoming dependent on someone else. Those who are most vulnerable, particularly the very frail, may not be able to anticipate a life crisis or an exploitive situation or to protect their own self-determination. These people need help to establish any level of prevention.

As noted earlier, many factors (alcoholism, drug abuse, a family history of violence, etc.) can indicate the potential for mistreatment. The goal is to recognize that these factors increase an older person's vulnerability and that plans should be made to reduce the threat.

Before accepting an offer of shelter and care, an individual should, if possible, assess potentials for difficulty in terms of caretakers' physical, emotional, intellectual, and financial resources. In fact, it is wise to make all decisions about what will happen in the future—or at least what you want to happen—while reasonably healthy and vigorous. There are legal and other procedures for making these arrangements. Before a crisis and with the involvement of the others concerned, aging persons should decide who is to care for them and manage their affairs if they become physically or mentally incapacitated. Although up to 80 percent of all personal health care of the elderly is provided by family members, few people prudently anticipate such difficult circumstances. Preparing for this eventuality should be as common as preparing a will.

It is wise to make all decisions about what will happen in the future while reasonably healthy and vigorous.

Incapacitation planning is best achieved in advance by identifying trusted and able individuals and then creating the legal mechanisms for transferring control to them. The former requires a solid assurance of the potential caregiver's willingness to accept the responsibility, as well as knowledge of his or her ability and stamina for what may be a prolonged period of personal care, the ability to help select an alternative care setting if necessary, and to manage assets and resources in good faith. The available legal mechanisms are numerous; if appropriate, a durable power of attorney is a good procedure to establish.

If individuals fail to make advance provision for incapacitation, the power of decision inevitably passes to others by such means as court-ordered guardianships or conservatorships. These procedures, which may take away an individual's control over his or her body, health care, domicile, and assets, have in some instances been notoriously abused as tools of exploitation.

Some Legal Processes

The following legal processes transfer personal control to others:

Power of Attorney—This is a document by means of which you authorize a designated person to act for you in one or a series of legal or financial transactions. It is usually initiated for a specific and limited period of time and becomes null and void if you become incapacitated.

Durable Power of Attorney—This is a document by which you empower another person to make legal, financial, or medical decisions on your behalf. A durable power of attorney is established in anticipation of a temporary or permanent incapacitation, since it will remain valid if you become incapacitated. It becomes effective once you have signed it. After you're incapacitated neither you nor anyone else can initiate a durable power of attorney.

Deferred Durable Power of Attorney—This becomes effective only after a determination has been made that the principal is incapacitated. Although such a determination can be the result of a court's declaration of incompetency or incapacity, and the appointment of a guardian, the normal motive for executing a deferred, or "springing," durable power of attorney is to avoid guardianship proceedings. To achieve the objectives, mechanisms can be incorporated for making a determination of incapacity as defined by the person involved. The principal may specify whether or not the deferred durable power of attorney applies to property, financial or asset management and personal health or medical decisions, in any combination. An example is to name two different parties, one of whom is the principal's physician who becomes responsible for making judgments in accordance with prespecified medical conditions.

The deferred durable power of attorney requires the principal to *anticipate* personal incapacitation. Just as it may be difficult to come to terms with the inevitability of death, it is often difficult to think about chronic disease or mental or physical incapacitation. To the greatest extent possible, however, the creation of protective measures, such as a deferred durable power of attorney, can reduce the likelihood of neglect or abuse.

Conservatorships and Guardianships—These are court procedures to provide the means of managing the person or personal affairs of an incapacitated person when no advance provisions have been made, such as a durable power of attorney, or when such advance provisions are challenged. These proceedings are sometimes necessary but they can have dire consequences because they largely eliminate an individual's right to self-determination and other personal rights and liberties. The procedures involve hearings before a judge, with or without witnesses. In many instances neither the person nor his or her advocate is notified to attend these hearings. Decisions of great consequence are often made with no one representing the person who is most affected. They are initiated by a petition to the court which declares the "principal" to be incapable of self-management or care. The petition can be filed by another individual who is legally related to the principal, by someone unrelated, or by a government agency—usually a social service or protective services department. In most states, a guardian is appointed to manage both person and property whereas a conservator is appointed to manage only property or assets.

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Public Guardians

The guardian or conservator is usually a relative or close associate of the incapacitated person, but the court can and does select persons known to the court who have no relationship to the incapacitated person. In some states, the court can designate an agency of government such as the "Department of Social Services" as the guardian, in which case no specific individual is held accountable and monitoring may be inadequate.

In conservatorships or guardianships, accountability is a technically and emotionally complex and controversial issue. Conservators or guardians can be paid out of the assets of the persons they manage without that person's consent. Courts exercise varying levels of oversight and evaluation of the appointment. While these procedures are necessary and inevitable in many situations, the potential for—and incidence of—unethical treatment or mismanagement is there. In general, therefore, these are provisions of last resort to be used when no other advance preparation has been implemented, when there is immediate need for personal management and supervision, when there is conflict within the family, or when no one related to the incapacitated person by law, business, or kinship is willing to accept the responsibility of conservator or guardian.

Conservatorships and guardianships are examples of the principle of *parens patriae*—the state as parent—the power of the state to assume "parental" control of individuals who cannot manage or provide for themselves. Since early in the century, many states have adopted varying ranges of authority under the *parens patriae* doctrine. Many who are familiar with these laws believe that they are commonly abused. There are great inconsistencies among the states (and even among judges in a single state) in such matters as safeguarding the rights of due process, legal advocacy and representation,

avoiding conflicts of interest, or limiting the powers of court-appointed guardians or conservators. In fact, some court interventions have constituted what to some appear to be officially sanctioned exploitation of the helpless.

Plenary and Limited Powers

Numerous legal scholars have called for the elimination of "total" or *plenary* guardianships and the use instead of "limited" guardianships. These latter are more closely monitored by the courts or designated individuals or agencies and are specifically limited to explicit responsibilities (shelter, nourishment, medical care, financial management) or to limited, prespecified time periods at which point the limited guardianship may be dissolved or renewed by the court. Limited guardianships, sometimes called "situational" or "special purpose" guardianships, are intended to curtail excessive powers of the state or its representatives over individuals and to maximize the freedom of choice and decision-making of incapacitated people for as long as possible. Some are, in fact, attempts to *prevent* the abuse, neglect, or exploitation of individuals by the state under the principle of *parens patriae*. The objective is to provide the least restrictive intervention possible.

A court hearing to decide whether or not a person should be declared incompetent or incapacitated stems from a petition to the court. The court is not automatically required to listen to advocates of the person whose fate is at stake unless there is a formal challenge to the petition. In other words, if you do not accept the necessity or advisability of someone else's petition that you be declared incompetent, you are entitled to and should have your personal physician and/or legal advocate present to represent your interests during the hearings. If at all possible, you should also be present at such hearings.

Under some states' statutes, the only "triggering cause" for the imposition of a total guardianship is "advanced age" with no evidence necessary of poor health or unsound mind.

Under some states' statutes, the only "triggering cause" for the imposition of a total guardianship—and the resulting irrevocable denial of the individual's rights—is "advanced age," with no evidence necessary of poor health or unsound mind. In many cases, "advanced age" is not further defined.

Incompetency

Incompetency hearings in many states fail to provide the same constitutional defenses for the incapacitated or abused person that must be provided for every offender in a criminal court. In some states, individuals who challenge an incompetency petition must provide their own defense.

Friends, relatives, or others have unethically used incompetency hearings to gain control of older persons' assets for personal use or exploitation. In some circumstances, a challenge to the incompetency petition can deny such persons fraudulent access to one's finances or property.

Advance planning, such as preparation of a legally valid power of attorney, can establish mutually acknowledged expectations among the people who otherwise would find themselves in critical, decision-making situations in which

emotions, fears and uncertainty could lead to costly mistakes. Plans for decisions about when incapacitation takes place, where and how the incapacitated will live, what medical care will be provided, and who will be in charge can all be made well in advance. The people involved have an opportunity to prepare for their new roles and responsibilities, and their expectations can be more thoughtful and realistic. The principal can explore alternatives for lodging, medical care, or asset management before decisions about them are required, and can maintain control over these arrangements without defaulting to the court or the state. While not infallible, this system may be the best currently available means for individuals to avoid becoming victims of neglect, abuse or exploitation associated with their own vulnerability and dependency upon others.

While there are relatively sophisticated legal mechanisms to protect vulnerable older persons, we have to remember that mistreatment is largely associated with personal limitations or isolation, and the people most likely to be mistreated are also the least likely to initiate self-protective measures. Another limitation on the legal transfer of control of person or property is that changes in the lives of the conservators (the caregivers) can reduce their ability to properly execute their assigned roles. There is always the possibility of eventual court intervention if caregivers themselves become incapable of managing the property or person of someone else.

Some Personal Dos and Don'ts

Prevention of all types of mistreatment other than passive neglect presents a challenge at the individual level much like that of preventing criminal acts by strangers. It is possible to parallel certain crime prevention strategies that apply to a household or domestic situation, such as "Do" and "Don't" lists to avoid burglary and mugging. For example,

Crime Prevention

DO

Notify police if you will be away for a long period.

DON'T

Leave messages on the door while you are away.

Abuse Prevention

The same kinds of precautions can be used to prevent domestic mistreatment.

DO:

- Remain sociable as you age; maintain and increase your network of friends and acquaintances. New activities can bring new friends.

- Participate in community activities as long as you are able. Be a volunteer or become a member or an officer of a new organization.
- Develop a mutual reassurance "buddy system" with a friend outside your home. Plan at least weekly contact and share openly with this person.
- Keep regular medical, dental, barber, hairdresser, and other personal appointments. These professionals can be helpful and, in special cases, could be used to attest to your levels of competency.
- Ask your friends to visit you where you live—even if it is just a room in someone else's home. Even brief visits will allow friends to check on your well-being and attitude.
- Have your own telephone and post and open your own mail. If mail is being intercepted, discuss alternatives with postal authorities.
- Keep your belongings neat and orderly and store your effects in a customary storage place.
- Make others aware that you know where everything is supposed to be.
- Expect records, accounts, and property to be available for examination by anyone you trust, in addition to the person you have designated or whom the court has designated to manage your affairs.

DON'T

- Voluntarily give up control over your property or assets until you determine that you cannot manage them.
- Leave cash, jewelry, or personally prized belongings lying about.
- Accept personal care in return for transfer or assignment of your property or assets without a lawyer, advocate or other trusted persons being involved as witnesses to the transaction.
- Lose contact with old friends and neighbors if you must move into a relative's home or another living arrangement.
- Allow anyone else to keep details of your finances or property management from you. Even if you have a guardian or conservator or have given someone a power of attorney, these representatives are acting as your fiduciary—which means that they must act on your behalf in good faith. You have a right to examine records and accounts or to see property.

Preventing Other Types of Mistreatment

Although it is difficult to anticipate physical abuse or violence against a vulnerable individual, there are practical techniques for primary prevention. As noted earlier, physical abuse is rarely the first form of mistreatment to emerge. Instead, it usually follows instances of emotional or verbal abusiveness and intentional neglect.

Physical abuse can often be prevented or avoided if other forms of mistreatment are recognized early. Individuals who are in jeopardy (those who have

been threatened, harassed, humiliated, or neglected) need to realize or be convinced that these forms of mistreatment are often the early warning signs of physical abuse. With this realization, they can prepare for some form of intervention or change in personal arrangements. However, physical abuse is far less common than other types of mistreatment, and verbal or psychological abuse or sudden declines in the physical status of the older person do not inevitably lead to more serious mistreatment. In fact, a long period of frailty with limited dependency can be associated with frustration and a high level of verbal or psychological abusiveness, but this behavior may be replaced by acute concern when the older person becomes severely ill and highly dependent.

It is difficult to predict which situations might trigger abuse or serious neglect. All sorts of barriers keep people from recognizing their own vulnerability or, if they do recognize it, from acting in ways that reduce their risks. Close relatives and long-term friendships and kinship ties are usually involved. The victims are almost always substantially isolated from the larger community, and they may fear increased mistreatment if they act in any way that calls attention to their circumstances. The family and the community, then, become central to any discussion about prevention of neglect or abuse because extended family members and communities maintain the constraints against mistreatment and the resources and capacity to alter abusive or neglectful circumstances. By not being immediately involved in the situation they can also initiate appropriate action.

What Can The Family Do?

Families provide most of the personal care of the frail elderly. The extended family can be instrumental in preventing neglect or abuse by recognizing the possibility of such mistreatment and knowing what to do. Family members can prevent mistreatment in two ways:

Families can be instrumental in preventing neglect or abuse by recognizing the possibility of mistreatment and knowing what to do.

- By watching for signs of mistreatment of older family members who are alone or in the care of others (perhaps other family members), and
- By avoiding actions that may lead them into abusive behavior. This can include acknowledging their limitations and surrendering the responsibilities of personal care for a frail relative if necessary or declining to accept the responsibility to begin with if their physical, emotional or financial abilities fall short of the levels required. Thoughtful self-examination should precede the decision to provide care for someone else, no matter how close or beloved. It can be a very difficult decision to make.

Family members usually have the best opportunity and are best suited to monitor the personal status of older relatives. Although contemporary America is characterized by family mobility and geographic dispersion, our modern communication system provides inexpensive and convenient opportunities for keeping up with relatives no matter how far away they live. Family members

are also the best sources of information about interpersonal conflicts, long-standing disputes or histories of abusiveness. They are in a far better position than public agencies to challenge a threatening custodial relationship of a frail relative. Family members, however, must be open to *suspecting* mistreatment. Not wanting to face symptoms of mistreatment and wanting to believe an abusive caretaker's explanations are more typical reactions within family systems than are suspicion and confrontation.

Family members can best prevent neglect or abuse of their aging relatives by avoiding the circumstances that might cause them to mistreat each other. Except in situations that are prompted by greed or retaliation for past events, most mistreatment is associated with inappropriate living and dependency arrangements among family members.

Adult children who are themselves aging, are chronically ill, or have limited financial resources should weigh the costs and potential risks of accepting or offering to take responsibility for a frail parent or other relative. While many people consider any form of home care to be superior to any form of institutional care, such beliefs are often based upon ignorance about institutions and an unrealistic sense of duty. Most families who accept the care of frail relatives do not anticipate the commitments of time or money to which their decision leads. By the time these become apparent, the family is already so beleaguered that it may be unable to reassess the situation realistically.

The decision to discontinue home care can tear a family apart, especially in cases when other relatives or friends make accusations of failure or abandonment. Many cases of neglect and abuse could have been prevented if a decision to discontinue home care had been made sooner.

Families can prevent mistreatment of older vulnerable relatives by considering the following suggestions:

DO

- Maintain close ties with aging relatives or friends. Keep abreast of changes in their health and ability to live independently.
- Anticipate potential incapacitation by planning, as a family, who will accept responsibilities, such as power of attorney or in-home caregiver when an aging relative becomes incapacitated.
- Become familiar with your older relative's financial records, bank accounts, wills, safe deposit boxes, insurance, debts and sources of income *before* he or she becomes incapacitated. Include your bank's trust department when planning for the financial security of the family. Plan together with the person how these affairs should be handled.
- Explore your older relative's wishes regarding health care, the expectations for home care in the case of incapacitation, the alternatives regarding terminal medical care and attitudes about the future use of personal assets.
- Closely examine your own ability to provide long-term care for a frail and increasingly dependent parent or relative. What are your physical limits? How will you decide to discontinue such a role? Can you afford

to offer the necessary care? What other family members' needs or plans will be affected? Will past relationships with the older person who is moving into your home cause conflicts with you or some other member of the household?

- Become familiar with community services to families and the aged. Chore services, housekeeping programs, home-delivered meals, senior recreation and day care, respite care and transportation assistance are available in many communities.
- If you plan to assume primary responsibility for an older relative, discuss your plans with your attorney, physician, and family members. Ask for their help if you need it.
- Plan how your own needs will be met when your responsibility for the dependent older relative increases.
- Explore alternative sources of care, including nursing homes or other relatives' homes, in case a need for a change develops.
- Discuss your plans with your friends, neighbors and other sources of support before your responsibilities become a burden. Ask for their understanding and emotional support. You may need it.
- Examine the physical realities of the home and property into which a frail relative will move. Do you need a first-floor bathroom, bedroom, or entry ramp? Can you manage a wheelchair? Will carpets or stairs become barriers? Do you need to fence the yard to prevent a loved one from wandering away? Does your kitchen allow you to prepare special diets or store medications properly? Can you move the dependent relative safely in case of fire?
- Prepare to maximize the older person's independence with a private telephone and other beneficial changes in the home, if possible.

DON'T

- Accept or offer personal home care unless you thoroughly understand the responsibilities and costs involved.
- Assume that poor interpersonal relationships between you and the older person involved will disappear. They won't!
- Expect irritating habits or problems, such as alcohol abuse, to be stopped or controlled once the dependent moves into your home.
- Expect to "do it all" and become superhuman. Find sources of help and *use* them.
- Ignore your own limitations and extend yourself beyond any benefit to you or to the person you love. This is how passive neglect begins.
- Label yourself a failure if home care is no longer possible and you must seek an alternative.

Families can also join together to form self-help and support groups, including sharing of specific responsibilities or periods of respite for each other. Extended families may, by their own existence, reduce vulnerability to neglect and abuse.

What Can The Community Do?

When individuals or families are not capable of anticipating potential mistreatment or not willing to alter the course of events that can lead to mistreatment, the community must intervene. Before a community can initiate specific actions, however, it has to agree on how to deal with concerns about privacy, the individual rights of adults (however vulnerable), roadblocks in provision of services and restraint of unbridled public intervention. The least restrictive alternative must be the goal.

When newly recognized social problems such as elder abuse come into public consciousness, suggested "solutions" often fail to address the actual causes or consequences, or they become mere political gestures. Public recognition of domestic mistreatment of older community residents will raise short-term consciousness, but that is likely to be followed by public actions that tend to ignore the intensely personal nature of the problem. As adults, the victims of neglect or abuse hold all the rights, privileges and responsibilities of all citizens including the right to self-determination, and to refuse treatment or intervention by public or private agencies.

Public intervention may be appropriate only when criminal damage to a person or his property is involved, when there is the clear likelihood of serious injury or death, or when there is a threat to public health or safety. At such a point, unfortunately, the most common outcome of a reported case of neglect or abuse of an older person is the imposition of an unlimited guardianship or conservatorship with little consideration of the victim's desires. Only rarely are criminal charges brought against criminally culpable caregivers, because many abused older persons fear reporting. These circumstances have tended to further victimize the abused, and to reinforce the need for a new emphasis on prevention at the community level.

Most neglected or abused persons can be expected initially or repeatedly to deny the nature of the problem. Similarly, neglectful or abusive caregivers rarely acknowledge their inability to provide care or their culpability for intentional mistreatment. When domestic mistreatment becomes a *public* issue the public will bear the costs associated with continued mistreatment. Therefore, it is in the community's best interest to reduce the need for institutional care of the frail or for court or police intervention. This action, coupled with the community's moral and humanitarian standards, can form a sound base for the community's efforts to prevent domestic neglect and abuse of its older citizens.

The community must consider methods of preventing mistreatment in cases in which individuals or families cannot. The most isolated vulnerable elderly and their immediate personal relationships are largely invisible to the rest of a community. When older people have been seriously abused or neglected, they are rarely seen in public and are most often not included in religious, social or business activities. Because of their isolation most public systems will not identify these victims until the need arises for medical or nursing care or police intervention.

However, as outlined below, there are ways for communities to prevent mistreatment or abuse. Many of these suggestions can also help to upgrade the quality of life of the whole community.

- Communities can become aware of the possibility of mistreatment and the probability of individuals being at risk. This involves a process of investigation, public education, and public information. It is not useful to overly sensationalize these issues, yet sufficient public interest must be aroused to facilitate preventive activity.
- Family caregivers of dependent older persons can be recognized as significant parts of the total community and special efforts can be initiated to educate, train, and counsel them in caregiving, including discussion of the realistic limits of home care for the severely impaired.
- Community "gatekeepers" and services workers—primary care physicians, public health nurses, social workers, law enforcement officers, delivery personnel, transportation workers, utility workers, postal employees, and others—are the "eyes and ears" of most communities. These people can be trained to recognize threatening situations and to initiate appropriate action. This does *not* suggest a major intervention just because an older person is alone or is said to be eccentric. Community services can, however, attempt to involve isolated people in appropriate services or self-help programs. These individuals live in isolation and some are at risk because they lack information. Community outreach may be welcomed.
- Gerontology should not be a study confined to universities or hospitals; communities can also educate themselves about the aging. Information on the biological and social effects of aging should be as common in public education as information about how to care for small children. This would have long-range benefits, including the prevention or early recognition of many forms of mistreatment.
- Workers in a variety of public agencies can be given basic training in responses and case management. No public representative in these systems should remain oblivious to the problem of neglect or abuse of the elderly or ignorant about their causes or remedies.
- The public and private sectors can improve their ability to help caregiving families, who carry the largest burden for highly dependent older persons. Many of these caregivers are near or beyond retirement age, with fixed incomes and increasing health problems.
- Communities can develop the means to provide direct assistance to caregiving families, strive to respond in crisis situations so as to help continue home care, if it is indicated, and assist families that face the difficult decision to discontinue home care. Through public awareness programs, communities can do more to advocate the causes of caregiving families and the needs of victims of passive or active mistreatment.

Information on the biological and social effects of aging should be as common in public education as information about how to care for small children.

- Neighborhood Watch programs and similar initiatives can be expanded to include training programs on home care of the frail elderly, on the signs of mistreatment, and on how to provide assistance or referral or to initiate intervention if it becomes urgently necessary.
- Communities can become more involved in aging service programs including those at nursing homes and senior citizen housing projects. Community involvement and awareness can upgrade or reinforce the quality of facilities or services.
- Communities should begin to understand that many forms of domestic mistreatment of the elderly are crimes and should be treated as such. Concerned community members can help victims file formal complaints, seek compensation for losses, and prosecute culpable parties. They can also help victims locate suitable assistance if their caregivers are prosecuted. Prosecution may result in sentencing or it may involve diversion, training, counseling or other types of family assistance services in lieu of criminal sanctions. Communities should expect and urge their officials to provide services that are necessary to assist victims of mistreatment.

Older persons are nearly always the best advocates for finding solutions to the problems and issues they confront. But older victims of domestic mistreatment are often least able to advocate their own causes, and their communities must accept the challenge for them. If they do, we will be able to prevent the domestic neglect and abuse of the elderly from becoming as prevalent as other forms of criminal victimization and violence.

Asking for Help. . . .

In many areas of the United States there are state, area or local public service agencies that can provide information, referral or guidance, depending upon the problem. Examples are Agencies on Aging, social or protective services, or mental health organizations, law enforcement, courts and civil or criminal justice services, religious organizations, charities and emergency response groups, among others. The following can help identify some of the services that you may find available.

Adult day care
Alcohol counselling
Attorneys, city/county
Board and care services
Chore services
Civil commitment procedures
Clothing, emergency
Court orders
Criminal complaints
Crisis intervention
Drug abuse counselling
Emergency services
Family counselling
Financial support
Foster care
Guardians/conservators
Health care services
Homemaker services
Housing alternatives
Law enforcement services
Legal services
Meal preparation
Meals, home delivered
Medical services
Mental health agencies
Money management
Nutrition sites
Nursing care, custodial
Nursing care, intermediate
Nursing care, skilled
Protective services
Religious, spiritual support
Reporting abuse
Representative payees
Respite (caregiver)
Restraining orders
Shelters, emergency
Support groups
Transportation
Telephone reassurance programs
Visiting nurses

Related Terminology

This brief glossary of terms is provided to aid readers who may not be totally familiar with them. They are not all-inclusive nor do they cover many of the legal or technical issues involved in their subjects. They are simply stated for easy comprehension.

Since governing statutes and regulations are so widely varied and definitions of mistreatment are not commonly shared, clarification or application of precise legal definitions of these and other terms should be sought from qualified attorneys, legislative reference services, or other professionals providing services to older persons.

Agencies on Aging—Local, Area or State

Governmental agencies designated in the Older Americans Act of the United States Congress to coordinate the delivery of services at the local level supported by Federal funds. An Area Agency on Aging usually comprises a city, county or group of counties whose respective agencies serve as information and referral sources for families seeking assistance with the care of an aging family member, or for an aging citizen in his or her own behalf.

Alzheimer's Disease

(Identified by German neuropathologist Alois Alzheimer in 1906) the condition in which the subject suffers changes in memory, thought, personality, language and other characteristics, becoming progressively incapacitated and dependent until the occurrence of death, usually from a secondary cause.

Chore Services

Services to provide minor home repairs, seasonal maintenance, or routine tasks that are beyond the physical capacity of the occupant. Chore services can be either non-profit or for profit, and frequently under contract with an Area Agency on Aging to provide services to low income elderly, and often provided on a sliding fee schedule based upon the ability to pay.

Conservator

An individual, usually designated by a court to manage the financial assets of an incapacitated person. Generally used as a limited form of guardian; a protector, custodian.

Conservatorship

The instrument of appointment of a person to protect, manage or conserve the assets of one who is incapacitated. Customarily applied to manage resources, and not the person, of the incapacitated ward.

Criminal Act
A breaking of the law, either a misdemeanor or a felony; a violation of a statute or of the common law; to be tried in a criminal court.

Criminal Intent
The knowledge that one is performing an unlawful act; the intent to commit a crime.

Criminal Justice System
The American system of criminal justice; a network of police agencies, courts and correctional institutions with varying degrees of autonomy and interdependency, acting toward the common purposes of prevention and control of crime. The criminal justice system itself does not make laws, but upholds them. This responsibility is evident in the design of the three primary segments of the system: (1) enforcement, (2) adjudication, and (3) corrections.

Criminal Offense
An offense to be tried in a criminal rather than a civil court.

Exploitation
In the context of abuse, to make illicit, unlawful or unethical use of, or to make a profit from, the labor or assets of another.

Fiduciary
Designating or of a person who holds something in trust for another; held in trust (as in fiduciary property).

Guardian
A person or agency, usually appointed by the court, who is given authority to control, manage, and protect a person and his or her financial and property assets. A guardian can be given authority to determine how finances are spent or invested, how and where a person lives, or how or when the person of concern is incapacitated and unable to make reasonable decisions regarding personal safety or property and asset management; and when there is no one available, capable, or willing to assume power of attorney. The guardian can be a relative or family member, or a total stranger (generally an attorney in the latter case, depending upon local court practices).

Guardian Ad Litem
A special guardian appointed by the court to represent the interests of an individual declared to be incompetent, who is a party to a suit or certain litigation.

Guardian, Limited

If the court finds that the proposed ward is incompetent in only certain aspects of life (e.g., forgets to pay bills), but retains capacity to function properly in other aspects (e.g., living in and managing one's own apartment), the court should appoint a guardian or conservator with powers to act only in the ward's area of incompetence.

Guardian, Public

A guardian appointed by the court, who is deemed to be an officer of the court. This person may be appointed to guardianship over many incompetent or incapacitated persons. The appointee may be paid for services from public funds or from assets of the incapacitated person of concern, if such funds are available. These determinations are made by the court.

Guardian, Plenary

A person, or agency, designated by the court to exercise control over the person and assets of an individual determined to be incompetent to do so. In this context, plenary means full, entire, complete, absolute, unqualified.

Health Care, Home

Nursing, medication, nutritional, hygienic or other personal services provided to frail or invalided persons. Usually for short time periods; however, some forms of care can require daily visits for extended periods. Coordinated by hospitals, medical group practices, or Area Agencies on Aging.

Incompetency

Synonymous with "incapacitated"; most commonly caused by medical conditions that tend to accompany aging, such as stroke, Alzheimer's disease, accidents, mental illness, or heart conditions or other degenerative problems.

In Loco Parentis

A Latin term meaning "in the place of parents." While usually used in cases involving the surrogate care of children, this term has been used in the context of long-term care of certain elderly, frail or incapacitated persons.

Intervention

A person's acting in behalf or in the interests of another upon request, or upon perceiving a need and governed by established criteria and accountability.

Legal Advocate

An attorney, legal consultant, or legal aid service organization that represents the interests of an individual or group of individuals, who usually are unable to represent themselves in matters of a legal nature.

Liability

The legal responsibility or obligation to do or not to do a specific thing, or to behave in a certain manner. Failure to perform can result in civil or criminal prosecution, and penalties.

Nutrition Site

A free-standing building or set-aside space in a larger structure (such as in a housing project) for the provision of low-cost or free nutritious meals for the elderly (over 60 years old) provided by funds authorized in the Older Americans Act. Coordinated by an Area Agency on Aging, as authorized by the same statute.

Parens Patriae

A legal principle meaning that the state or the government can act to determine what is in the best interests of an individual, even if the individual disagrees, on the basis of evidence of incapacitation or charges of personal or serious property mismanagement. Literally, the "father of the country."

Protective Services, Adult

A public or non-profit service that acts on the suspicion or a report of evidence to determine if an adult is at risk for personal injury, harm, or less directly due to actions or inactions of others or to the personal inability to care for him or herself or property. Protective services agencies generally undertake case management or referral until the charges are verified and resolved to the advantage of the individual or concern, or dismissed as invalid.

Spouse Abuse (Late-onset)

Physical or psychological abuse of a spouse that has not been a characteristic of the marriage until one or both partners are advanced in age. Such mistreatment is associated with personal changes or altered circumstances that are linked to being elderly or to personal aging.

Spouse Abuse (Longstanding)

Physical or psychological abuse of a spouse; abuse that has been characteristic of the marriage for many years. With elderly couples, such abusive behavior has been part of the marital relationship for more than half of the marriage's length. Causes for such mistreatment are not related to aging or to age-related events of the marital partners.

Trust, Living

An authorization, a signed document, usually to family members or business partners, to manage financial affairs in specific ways in the event of death.

Trust, Protective

A trust in which the Trustee, fearful that the beneficiary will not handle his or her assets wisely, can use discretion in disbursing monies to the beneficiary.

Will, Living

Signed, dated and witnessed document which allows the subject to state in advance wishes regarding the use of life-sustaining procedures when dying. It also has a provision for the appointment of someone else to direct care if the subject is unable to do so.

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